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Raymond Gibbons

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PAYMENT CHANGES NECESSARY TO CATALYZE HIGHER-QUALITY, LOWER-COST CARE

RAYMOND GIBBONS, M.D., JEFFREY KORSMO,* &
ROSHELLE PLUTOWSKI†

During the 2010 mid-term election campaign, the new health care law—The Patient Protection and Affordable Care Act (PPACA)¹—continued to be hotly debated by both political parties. Three states voted on ballot measures that contested the constitutionality of an individual mandate to buy health insurance.² A coalition of states called for the repeal of the law on the grounds that the Medicaid expansion would impose a huge fiscal burden on state budgets.³ Interest groups began lobbying efforts to change selected provisions.⁴

Vigorous civic debate reflecting multiple points of view is a hallmark of a vibrant democracy. Some of the debate has been authentic and productive. However, some public discourse on health care reform has disintegrated into partisanship, fear mongering, and finger pointing. It appears that we Americans and our elected officials have not yet agreed on the fundamental goal of health care reform and how to develop policies that will support it.

Nearly six years ago, Mayo Clinic became more publicly engaged in the health care reform debate because a confluence

* Dr. Gibbons and Jeffrey Korsmo are both senior leaders at Mayo Clinic and have collaborated on health care reform efforts through the Mayo Clinic Health Policy Center.

† Mayo Clinic Health Policy Center. The authors thank Shelly Plutowski for her editorial contributions to this manuscript.

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) [hereinafter PPACA]. For ease of reference, PPACA as used here also includes amendments made to it by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

2. See Julian Pecquet, *Midterm Voters in Three States Will Cast Ballots on Healthcare Insurance Mandate*, THE HILL (Nov. 1, 2010, 12:36 PM ET), <http://thehill.com/blogs/healthwatch/politics-elections/126801-states-hold-referendums-on-individual-mandate>.

3. See Rick Schmitt, *Suits Over Health Care Law Heat Up*, USA TODAY, Oct. 6, 2010, at 1B.

4. See Dan Eggen, *For Many Interest Groups, Health-Care Bill's Passage Doesn't Stop the Fight*, WASH. POST, Mar. 24, 2010, at A05.

of issues pointed to serious trouble ahead: increasing numbers of uninsured, uneven health care quality and safety throughout the country, skyrocketing costs, and an impending explosion of baby-boomers reaching Medicare age. Through the efforts of our non-partisan Mayo Clinic Health Policy Center, thousands of patients, providers, academics, medical industry leaders, employers, insurers, and policy makers have come together to develop and advocate for four cornerstones of reform: create value, coordinate care, reform the payment system, and provide health insurance for all. These principles reflect a shared vision: quality, affordable health care for all Americans. We call this high-value health care.

Throughout the debate on health care reform, Mayo Clinic used these four cornerstones as standards against which to evaluate legislative proposals. Even though we did not take a formal position regarding the final legislation, we continued to articulate our areas of agreement and areas of concern with PPACA.

We believe that some PPACA provisions are aligned in principle with our cornerstones for reform, such as:

- Insurance reforms, including an individual mandate to buy insurance and the elimination of exclusions for pre-existing conditions.
- Subsidies for people who need financial help to purchase health insurance.
- Accountable care, medical homes, and bundled payments as alternatives to better coordinate care and lower costs.

At the same time, we expressed significant concern with some of the financing and cost-containment elements of the law, including:

- Across-the-board provider cuts, which punish the good and bad equally.
- The timeline and scope for studying and implementing new payment models.

Although the law does take some first steps to reward doctors and hospitals that deliver value—better health care outcomes at lower costs—these provisions are not comprehensive or aggressive enough to have an immediate impact on lowering costs and improving quality. Much stronger provisions are required to change the trajectory of American health care.

Current fee-for-service reimbursement schemes reward medical piecemeal—performing diagnostic tests, procedures, and surgeries. It is therefore not surprising that U.S. health care is dominated by such costly services. Each year, Medicare issues its

annual payment rate update rules for thousands of services in hundreds of geographic regions. The complex payment formula includes physician work, practice expense, malpractice expense, geographic cost variations, and a conversion factor that has been adjusted to ensure budget neutrality. Through its focus on payment per service, this seriously flawed approach promotes overuse of procedures and fuels rising health care costs. Doctors are financially rewarded for *doing more*, not for providing quality, affordable health care.

In his widely cited *New Yorker* essay “The Cost Conundrum,”⁵ Atul Gawande, M.D., tells the tale of two Texas cities of similar size, location, and demographics—El Paso and McAllen—which have substantially different annual costs for Medicare beneficiaries. In 2006, McAllen cost Medicare \$14,946 per enrollee, while El Paso cost about half of that—\$7,504 per enrollee. Gawande’s initial premise was that the quality of care in McAllen must be superior, but further review of delivery system performance disproved this theory. He concluded:

Analysis of Medicare data by the Dartmouth Atlas project shows the difference is due to marked differences in the amount of care ordered for patients—patients in McAllen receive vastly more diagnostic tests, hospital admissions, operations, specialist visits, and home nursing care than in El Paso. But quality of care in McAllen is not appreciably better, and by some measures, it is worse. . . . [T]he care for patients in the highest-cost regions of the country tends to go this way—with more high-cost care across the board, but less low-cost preventive services and primary care, and equal or worse survival, functional ability, and satisfaction with care⁶

Believing that more care is better, individual patients sometimes contribute to the problem of overutilization by demanding services from their doctors. However, research supports a counter-intuitive mantra: less is often better when it comes to health care. For example, two cardiology studies have found that less expensive drug therapy is just as effective at reducing future cardiovascular events and death as heart bypass surgery or coronary artery stenting.⁷ Bone marrow transplantation was widely

5. Atul Gawande, *The Cost Conundrum*, NEW YORKER, June 1, 2009, at 36.

6. Atul Gawande, *The Cost Conundrum Redux*, NEW YORKER (June 23, 2009), <http://www.newyorker.com/online/blogs/newsdesk/2009/06/atul-gawande-the-cost-conundrum-redux.html#ixzz14uZkvVXL>.

7. See BARI 2D Study Group, *A Randomized Trial of Therapies for Type 2 Diabetes and Coronary Artery Disease*, 360 NEW ENG. J. MED. 2503 (2009); William

performed for women with breast cancer until studies showed that it brought no benefit.⁸ Research has also shown that using less expensive generic drugs to treat high blood pressure is just as effective as treatment with more expensive brand-name drugs.⁹

Too often, however, this new evidence does not make its way quickly into practice, and overutilization of expensive therapies continues. The country—individuals, employers, and our government—simply can't afford the status quo. The rising cost of health care affects everyday Americans by reducing the amount of money they have for other necessities, causing them persistent financial stress. Making an effort to compete both locally and globally, small and big businesses alike defer job creation and business growth as they struggle to manage exploding health care benefit costs. Meanwhile, state and federal governments—attempting to balance shrinking budgets—reduce provider payments for public health insurance programs. In turn, hospitals and doctors charge more to patients with commercial insurance, are incentivized to reduce access to patients on public programs, and boost the number of services they provide to mitigate the cuts. Thus, costs rise while patient satisfaction and access decline. American health care remains trapped in this downward spiral.

How can we interrupt this deeply ingrained pattern? We must take the critical first step to fundamentally realign the financial incentives that drive the way care is delivered. We must strengthen efforts to pay for the desired result: high-value health care. Democrats and Republicans have expressed support for this approach. Health and Human Services Secretary Kathleen Sebelius told the American Hospital Association that it is critical to “change the incentives in our health care system so doctors and hospitals get rewarded for delivering high quality care. . . . [W]e pay too often for quantity, not quality. For volume, not value.”¹⁰ Likewise, prominent Republican leader Bill Frist wrote in *The*

E. Boden et al., *Optimal Medical Therapy with or without PCI for Stable Coronary Coronary Disease*, 356 NEW ENG. J. MED. 1503 (2007).

8. See Edward A. Stadtmauer et al., *Conventional-Dose Chemotherapy Compared with High-Dose Chemotherapy plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 NEW ENG. J. MED. 1069 (2000).

9. See ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group, *Major Outcomes in High-Risk Hypertensive Patients Randomized to Angiotensin-Converting Enzyme Inhibitor or Calcium Channel Blocker vs Diuretic: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT)*, 288 JAMA 2981 (2002).

10. Kathleen Sebelius, Address to the American Hospital Association (Apr. 26, 2010), available at http://www.troncommunications.com/Productions/kathleen_sebelius.wmv.

New York Times that “[t]he most powerful way to reduce costs (and make room to expand coverage) is to shift away from ‘volume-based’ reimbursement (the more you do, the more money you make) to ‘value-based’ reimbursement.”¹¹

We recommend that Congress set a five-year deadline for creating and implementing new Medicare payment methods, using a mechanism within PPACA—The Center for Medicare and Medicaid Innovation (CMI).¹² This new office is tasked with researching, developing, testing, and expanding innovative payment models and care delivery arrangements to improve value for patients enrolled in each federal program. One approach would be for Medicare to establish new value-based payment methods for the most expensive three to five conditions and procedures—sending providers the message that they must begin re-engineering care delivery to create higher quality, lower-cost care for patients. Another approach would be to base a portion of Medicare payments on value, rewarding those who offer high-quality, affordable care and providing an incentive for others to improve. (Data are currently available to measure and compare providers’ performance.)¹³ Over time, we believe that health care professionals would change key behaviors—for example, sharing information and eliminating unnecessary tests—that would lead to better, less-expensive care.

Unfortunately, efforts to provide high-value care are frequently penalized by the existing reimbursement system. Seattle-based Virginia Mason Medical Center (VMC) took a fresh approach to this problem by working with Aetna and several big regional employers to redesign how providers treated patients with common, expensive medical problems such as migraine and back pain.¹⁴ As the groups worked to standardize the care—through same day access and evidence-based care that reduced the number of expensive tests and specialist visits—the costs for purchasers went down quickly, but the medical center also lost money. For example, each avoided MRI saved the purchasers about \$850, while VMC lost about \$450 in profit. Working together, the group realigned reimbursement—increasing payments for physical therapy sessions, for example—so that the

11. Bill Frist, Op-Ed., *How the G.O.P. Can Fix Health Care*, N.Y. TIMES, Feb. 22, 2010, at A19.

12. PPACA, Pub. L. No. 111-148, § 3021, 124 Stat. 119, 262 (2010).

13. See Robert K. Smoldt & Denis A. Cortese, *Pay-for-Performance or Pay for Value?*, 82 MAYO CLINIC PROC. 210 (2007).

14. Vanessa Fuhrmans, *A Novel Plan Helps Hospital Wean Itself Off Pricey Tests*, WALL ST. J., Jan. 12, 2007, at A1.

medical center could break even or make a small profit on the higher-value care they were providing.

Moving forward, we must ensure that health care in the United States is patient-centered, coordinated, accessible, affordable, and that it provides better value—whether that care is provided under Medicare or any other insurance program. It is time for health care providers to take a leadership role in creating high-value care that will yield affordable insurance, lower health care costs, and better health for the people of our nation. The challenge for providers is two-fold: Do the *right thing*, and do the *thing right*. Insurers must reward these efforts and remove the perverse incentives that favor more tests and procedures in the existing system. Patients must learn that more care is not necessarily better and take greater responsibility for their own health by making lifestyle changes to prevent disease. The challenges are daunting, as meaningful reform requires painful changes by nearly everyone, but our nation can no longer afford the status quo.